# MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
## Communicable Disease and Immunization Division
## VIRAL CNS INFECTION CASE INVESTIGATION

(Please check appropriate illness)

___ Paralytic Polio ____ Aseptic Meningitis **Identify if Outbreak Related:**

____ Encephalitis or Meningoencephalitis ____ Arbovirus Encephalitis _____

*Note: If **polio** suspected, call MDCH for further guidance immediately.*

**CASE IDENTIFYING INFORMATION**

Name: _____ Age or Birth date: _____ Sex: ____ Race: _____

Address: _____ Home Phone: _____
(Street) (City) **(County)**
Work Phone: _____

Occupation: _____ Place of Employment: _____
(If infant or student, list school or day care)
Attending Physician: _____ Address & Phone: _____

Patient Hospitalized: **Yes or No** Hospital: _____
(Admission date) _____ (Discharge date) _____ (City) _____
Survived: **Yes or No**

**DATE OF SYMPTOM ONSET:** _____

**CLINICAL INFORMATION FROM ATTENDING PHYSICIAN: (Circle all that apply)**

| | | |
|---|---|---|
| Fever | Confusion/memory loss | Upper respiratory symptoms |
| Headache | Sensory abnormalities | Rash |
| Stiff neck/back | Convulsion/tremor | Herpes sores (within 1 month) |
| Lethargy/somnolence | Photophobia | Stupor/coma |

Muscle weakness/paralysis (what muscles?) _____

Other symptoms: _____

Lumbar puncture/CSF examination: **Y or N**
If **yes**: **CSF white blood count**: _____ **Differential:** _____
Other CSF results: **Glucose** _____ **Protein** _____ **Bacterial antigens**_____
If **NO**, how was diagnosis made:_____

Other relevant clinical information: _____

| **Virology (if obtained)** | **Acute Serum** | **Convalescent serum** | **Feces** | **CSF** |
|---|---|---|---|---|
| **Date Spec. Obtained** | | | | |
| **Lab Testing Spec. & Test Type** | | | | |
| **Results** | | | | |

## EPIDEMIOLOGY
## (Obtain from families)

Within **one month** of the onset of symptoms in the patient : **(please circle the appropriate response)**

| | | |
|---|---|---|
| 1) | Does the patient know of anyone else with a similar illness? | **Yes No** |
| 2) | Was the patient exposed to anyone with a respiratory, gastro-intestinal or rash illness? | **Yes No** |
| 3) | Did the patient travel outside the country? | **Yes No** |
| 4) | Was there heavy exposure(s) to biting insects? | **Yes No** |
| 5) | Has the patient received an organ donation/blood transfusion? | **Yes No** |
| 5) | Is the patient pregnant or nursing? | **Yes No** |
| 6) | Has the patient ever received a vaccination for a flavivirus (Japanese encephalitis or Yellow Fever)? | **Yes No** |
| 7) | What was your occupation during the last month? | _____ |
| 8) | What were you doing when you were most likely exposed to mosquito bites? | _____ |
| 9) | During the last month, did you regularly wear mosquito repellant when outdoors? | **Yes No** |

**For any yes** answers to the questions above, provide all relevant details (including names, addresses, phone numbers, places, dates, etc.) In the space below or on a separate page to be attached.

| Name | Address | Phone # | Date | Places | Other Comments |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

Home drinking water: **well** **city** **Other**_____

Home sewage system: **septic tank** **city** **Other**_____